We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

LETTERS

CRISTINA PEDRAZZINI/SPL

SUICIDE RISK

Bipolarity is important during treatment with antidepressants

Rubino et al have identified that most (if not all) of the excess risk of suicide in a group of patients treated with venlafaxine could be explained by a higher burden of risk factors for suicide. It may be true that this group of patients had more severe or "difficult to treat" unipolar depression, but it is also possible that bipolar features in this group may be responsible for the observed raised rates of suicidality. Perhaps because of limitations of space, the authors do not discuss this as a possibility, despite an adjusted relative risk of completed suicide of 4.94 (95% confidence interval 1.30 to 18.84) for "past history of bipolar disorder" (table 3).[1]

Recent work shows that at least 50% of difficult to treat unipolar depressed patients may have an undetected bipolar disorder,[2] and it is now well documented that antidepressant monotherapy for bipolar depression runs a high risk of precipitating hypomanic or mixed affective states,[3] which have been strongly associated with self harm and completed suicide.[4] It is also the case that venlafaxine seems more likely than other antidepressants to precipitate a switch into hypomania or mania in bipolar depression.[5] Furthermore, many of the variables reported by Rubino et al could be considered to point towards high levels of bipolarity in the venlafaxine treated group, including higher rates of a family history of psychiatric disorder, more frequent prescription of antipsychotics and mood stabilisers, a history of non-response to several different antidepressants, and more frequent lifetime depressive episodes.

Daniel J Smith clinical lecturer, Cardiff University, Cardiff CF14 4XN smithdj3@cardiff.ac.uk

James T Walters clinical lecturer

Competing interests: None declared.

1 Rubino A, Roskell N, Tennis P, Mines D, Weich S, Andrews E. Risk of suicide during treatment with venlafaxine, citalopram, fluoxetine, and dothiepin: retrospective cohort study. *BMJ* 2007;334:242-5. (3 February.)
2 Sharma V, Khan M, Smith A. A closer look at treatment resistant depression: is it due to a bipolar diathesis? *J Affect Dis* 2005;84:251-7.
3 Goldberg JF, Truman CJ. Antidepressant-induced mania: an overview of current controversies. *Bipolar Dis* 2003;5:407-20.
4 Akiskal HS, Benazzi F, Perugi G, Rihmer Z. Agitated "unipolar" depression re-conceptualized as a depressive mixed state: implications for the antidepressant-suicide controversy. *J Affect Dis* 2005;85:245-58.
5 Post RM, Altshuler LL, Leverich GS, Frye MA, Nolen WA, Kupka RW, et al. **Mood switch in bipolar depression:** comparison of adjunctive venlafaxine, bupropion and sertraline. *Br J Psychiatry* 2006;189:124-31.

Suicidal and self harming behaviours may be distinct

Classifying the method as well as the motivation of self harm is important since the physiological mechanisms lead to different perceived and actual outcomes.[1] If the motivation is truly suicidal, a non-fatal outcome is unsuccessful, but where the motivation is not suicidal, death is accidental.

Overdoses of drugs or poisons are more likely to be lethal and, if unsuccessful, to result in hospital admission, whereas self harm involving physical injury such as cutting or hitting an inanimate object is more commonly encountered in the community.

Suicide numbers in studies can be increased by including people who injure themselves using highly painful methods with low lethality, but suicide studies require differentiation between these groups to retain validity. If self harm patients who die accidentally are included this will have a skewing effect on postmortem studies of suicide.

In our clinical practices in the community we recognise many patients who regularly use low lethality, high pain methods such as cutting, scratching, or other physical trauma to modify mood. We have previously hypothesised an aetiology for this self harm based on an imbalance of endogenous opioids[2] and have developed a treatment. Reductions in self harm behaviours were achieved by using low frequency transcutaneous electrical nerve stimulation (TENS)[3] for a limited time, during which subsequent resolution of self harm behaviour and urges was achieved by using psychotherapy (unpublished data). In these cases we assumed a psychological stimulus for the enduring opioid imbalance and used Shapiro's concept of adaptive information processing to address the root problems with trauma-specific eye movement desensitisation and reprocessing.[4]

Philip V Dutton consultant clinical psychologist, Synapse, Stirling FK8 1HF pdutton@health-psychology.co.uk

Andrew J Ashworth general practitioner, Davidson's Mains Medical Centre, Edinburgh EH4 5BP

andrew.ashworth@lothian.scot.nhs.uk

1 Cipriani A, Geddes JR, Barbui C. Venlafaxine for major depression. *BMJ* 2007;334:215-6. (3 February.)
2 Ashworth AJ. Endogenous opiate activity imbalance - a physiological basis for psychosocial dysfunction? www.bmj.com/cgi/eletters/bmj.38790.495544.7Cv1#131910
3 Han JS, Chen XH, Sun SL, Xu XJ, Yuan Y, Yan SC, et al. **Effect of low- and high-frequency TENS on Met-**enkephalin-Arg-Phe and dynorphin A immunoreactivity in human lumbar CSF. *Pain* 1991;47:295-8.
4 Shapiro F. *Eye movement desensitisation and reprocessing: basic principles, protocols and procedures*. 2nd ed. New York: Guilford Press, 2001.

IQ AND VEGETARIANISM

Non-conformity may be hidden driver behind relation

The link between childhood IQ and vegetarianism in later life is perhaps not driven by a causal chain of mechanisms related to health.[1] As the number of vegetarians in the population is low, vegetarianism could be considered as a type of non-conformist behaviour.

Non-conformist behaviour may threaten the extent to which a person belongs to a social group, or has the potential of enlarging the psychological distance from others. People who deviate from the group are more likely to be punished, ridiculed, or even rejected by other group members.[2] Acquiring resources in isolation is more difficult than in groups.[3] The need to belong may therefore reduce people's inclination to act in a non-conformist way. However, general intelligence is a strong predictor of future resources.[4 5] Highly intelligent people can afford more non-conformist behaviour because of their capacity to secure resources in isolation. Therefore, we propose that as general intelligence increases, the need to conform to group norms decreases.

To test this hypothesis, we measured the "need for uniqueness"[5] and general intelligence. The need for uniqueness is measured by a scale with statements indicating a low level of conformity, such as "I often dress unconventionally even when it's likely to offend others." Our study (32 men, 14 women) showed a significant positive relation between the need for uniqueness and general intelligence (r=0.35, P=0.017). This relation was similar for men (r=0.32) and women (r=0.46).

Kobe Millet PhD student, Department of Marketing and Organization Studies, KU Leuven, Naamsestraat 69, 3000 Leuven, Belgium kobe.millet@econ.kuleuven.be

Siegfried Dewitte assistant professor

Competing interests: None declared.

1 Gale CR, Deary IJ, Schoon I, Batty D. IQ in childhood and vegetarianism in adulthood: 1970 British cohort study. *BMJ* 2007;334:245-8. (3 February.)
2 Baumeister RF, Leary ML. The need to belong: desire for interpersonal attachments as a fundamental human motivation. *Psychol Bull* 1995;117:497-529.
3 Gottfredson LS. Intelligence: Is it the epidemiologists' elusive "fundamental cause" of social class inequalities in health? *J Pers Soc Psych* 2004;86:174-99.
4 Kanazawa S. Why beautiful people are more intelligent. *Intelligence* 2004;32:227-43.
5 Tian KT, McKenzie K. The long-term predictive validity of the consumers' need for uniqueness scale. *J Consumer Psychol* 2001;10:171-93.

ENDOMETRIOSIS

Infertility set in context

With an evidence based approach, Farquhar reviews the most outstanding aspects of endometriosis.[1] Nevertheless, we were left with the impression that some important issues are in need of further clarification.

A systematic review has shown an improvement in pregnancy rates after laparoscopic treatment of endometriosis for women with infertility,[2] but this improvement seems to be true only for mild or minimal endometriosis and its effect on more advanced stages remains uncertain.[3 4]

A recurrence of endometriosis does not inevitably mean further surgery. The evidence supporting systematic surgery for asymptomatic endometriosis is poor, and it has been suggested that re-operation is not always indicated for recurrent endometriosis. Transvaginal aspiration might prove to be a reasonable alternative for some patients to reduce impact on ovarian reserve as well as other potential surgical complications associated with re-operation.[3]

Whether endometriosis affects outcomes in the context of artificial reproductive techniques is still under debate[3]; it has been proved in a recent systematic review that down-regulation with GnRH agonists for three to six months before starting in vitro fertilisation quadruples the odds of clinical pregnancy.[5] Early referral to centres of excellence and early treatment of infertility should be considered in these patients.[3]

Alejandro Chavez-Badiola fellow in reproductive medicine
Hewitt Centre for Reproductive Medicine, Liverpool Women's Hospital. Liverpool L8 7SS alejandro_bad@yahoo.it

Andrew J Drakeley subspecialist consultant in reproductive medicine

Competing interests: None declared.

1 Farquhar C. Endometriosis. *BMJ* 2007;334:249-53. (3 February.)
2 Jacobson TZ, Barlow DH, Koninckx PR, Olive D, Farquhar C. Laparoscopic surgery for subfertility associated with endometriosis. *Cochrane Database Syst Rev* 2002;(4): CD001398.
3 Chavez-Badiola A, Drakeley A. Optimising in vitro fertilisation (IVF) outcome in women with endometriosis. *Rev Gynaecol Perinatal Pract* 2006;6:153-60.
4 Royal College of Obstetricians and Gynaecologists. *RCOG green-top guideline for the investigation and management of endometriosis 2006 (24)*. www.rcog.org.uk/index.asp?PageID=517
5 Sallam HN, Garcia-Velasco JA, Dias S, Arici A. Long-term pituitary down-regulation before in vitro fertilization (IVF)for women with endometriosis. *Cochrane Database Syst Rev* 2006;(1):CD004635.

RACISM IN THE NHS

Doctors who look and speak differently may be mistrusted

The experiences of the anonymous doctor[1] are transferable to the thousands of visible minority doctors attempting to find career progression, satisfaction, and a sense of belonging in the NHS. Those who come to the United Kingdom having trained elsewhere are much less equipped to face these challenges.

It may be useful to remind ourselves what racism is. The *Oxford Dictionary* defines it as a belief in the superiority of a particular race and the prejudice based on this; antagonism towards or discrimination against other races and the theory that human abilities, etc, are determined by race.[2]

On a day to day basis, in the health service, racism often translates to discomfort and mistrust of doctors who look and speak differently. Such mistrust has serious consequences for many ethnic minority doctors. The threshold at which errors are tolerated is much lower, and the way the system will respond to the same errors made by these doctors compared with white doctors is different. This is partly responsible for the disproportionate number of ethnic minority doctors who appear before the fitness to practise committee of the General Medical Council. Even more serious is the disproportionate number of ethnic minority doctors who go to jail for manslaughter. Similarly progress to executive positions in hospital trusts or royal colleges is more difficult for these doctors. They are also under-represented in clinical excellence awards.

Satheesh Mathew consultant paediatrician, Newham University Hospital, London E13 8SL satheesh.mathew@ntlworld.com

Competing interests: None declared.

1 Anonymous. Collecting feathers in the health service. *BMJ* 2007;334:260. (3 February.)
2 Thompson D, ed. *Concise Oxford dictionary of current English, 9th ed*. Oxford: Clarendon, 1995.

Everyone has a race card

The debate on racism should be about the impact of expressed behaviour, rather than about intent.[1] Hence the absurd incessantly repeated refrain of "I know XYZ, and he's no racist," even after XYZ may have said or done something that is in fact unequivocally racist. By making it a commentary on the whole of that person's "character," it becomes expedient to minimise and even rationalise certain behaviours on the grounds that they occur "infrequently," are "aberrant," or are "not indicative of the norm," etc. We wouldn't do this if someone had picked up a chair and thrown it at someone, would we? "I know XYZ and he's completely non-violent."

We need to become more perspicacious and industrious about helping individuals see the impact of their daily low level bigotry in the lack of leeway they give to certain others, in the generalisations they make, in the disbelief they express even as these others describe their experiences of marginalisation, exclusion, harassment, ridicule, and even assault.

A mainstream person also has a race card—and he or she plays it far more often than a visible minority—because it is worth far more than the discredited race card of a visible minority. It is a trump of disbelief and dismissal—the ultimate form of prejudice where the person in the mainstream denies even the daily lived reality of his or her visible minority counterparts and colleagues.

Nav Khera education consultant, Sheffield S6 6QA Nkhera@aol.com

Competing interests: None declared.

1 Anonymous. Collecting feathers in the health service. *BMJ* 2007;334:260. (3 February.)